Arizona AIDS Drug Assistance Program 6 Month Continuing Enrollment Form
Arizona Department of Health Services

The ADAP program is obligated under Title 42 300 ff-27(b)(7)(F) of the United States Code to show that medications provided by ADAP reasonably cannot be expected to be provided through any other source. Applicants will be required to show that they have no available alternative other than the ADAP program that can provide the HIV treatment for which they are applying. In order to make this determination, the ADAP program may request additional information/documentation that establishes that there is no other provider source available to the applicant.

Instructions**: Please fill in all blanks. Submit documentation where requested.**

APPLICANT INFORMATION

Date _____

Name			
Last	**First**		**MI**
Birth date (month/day/year)	**AKA (also known by these other names)**		
Contact Information: Please describe any concerns you may have with staff contacting or leaving messages at the below numbers and addresses.			
Home Phone Number / Cell Number / Work Number (include extension)			List concerns/ limitations OK to leave messages ☐
Residential Address (where you live)			
Street Address / Apt/Suite #	City	State	Zip Code
May we contact you at this address? ☐ Yes ☐ No			
Mailing Address (Check here if same as residential address ☐)			
Street Address / Apt/Suite #	City	State	Zip Code
May we contact you at this address? ☐ Yes ☐ No			
Primary Representative Contact (parent or guardian)		**Aware of Status? Yes ☐ No ☐**	
Name	Phone Number		
Street Address	City	State	Zip
Person(s) &/or case manager ADAP may speak to regarding applicant's enrollment in ADAP			
Name	Phone Number		
Name	Phone Number		

Proof of Arizona Residency - REQUIRED
Please attach proof of residency per attachment B.

Employment Status for Applicant/Adult in the family unit – check all that apply
☐ Full time __ hrs per week ☐ Part Time ____hours per week ☐ Seasonal/ temporary ☐Unemployed ☐ Self employed ☐ Retired ☐ Other _____ (specify)
Are you or an adult in the family unit receiving public assistance? ☐ Yes ☐ No Are you or an adult in the family unit receiving regular monetary payments from a source other than employment or public assistance? ☐ Yes ☐ No If yes, list the source _____ Are you (the applicant) receiving other assistance in obtaining food, water, housing or clothing? ☐ Yes ☐ No If yes, list the source _____

Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI)	
I am currently receiving Supplement Security Income (SSI) ☐ Yes (if you are receiving SSI you are automatically eligible for AHCCCS) ☐ No If No, have you applied for SSI? ☐ Yes ☐ No	I am currently receiving SSDI ☐ Yes ☐ No If Yes, date started ___/____/_____, If No, have you applied for SSDI? ☐ Yes ☐ No

HOUSEHOLD INFORMATION AND TABLE

In the table below
List every person who lives with you (starting with yourself/applicant) and is related to you by legal marriage, birth, adoption
List the monthly gross income that each adult (age 18 or older, married or emancipated) brings to the household.
ALL EARNED AND UNEARNED INCOME MUST BE REPORTED and DOCUMENTED (see Attachment C for details)
If the adult applicant income is shown as $0, you will need to complete and sign the Certification of Income &/or Support Form (Attachment D) and have it signed by your Case Manager or Health Care provider.

Applicant or Family Member Name	Relation	Last 4 digits of SSN*	Adult? Yes No	Monthly Gross Income from all Sources (if under age 18, income is not required to be reported)
	SELF			

* This information is not used for eligibility determination. ADHS uses your Social Security number for computer matching with Arizona Dept of Economic Security to verify income, and AHCCCS to verify Medicare/Medicaid coverage.

Total Family Income and Size (enter totals from HOUSEHOLD INFORMATION TABLE)	
Total number of individuals living in family unit _____	Total Combined FAMILY Income from all Sources $_____ (Annual Income = Monthly Income x 12)

HEALTH INSURANCE

Please tell us if you are eligible to be enrolled in any of the following programs. You may be required to provide proof of denial if it appears you may be eligible. If you have medical coverage, please attach a copy of your health insurance card and prescription drug card.

Arizona Medicaid – AHCCCS if you are receive Supplemental Security Income you are automatically eligible for AHCCCS

I am approved or receiving AHCCCS ☐ Yes (Attached copy of letter/card) ☐ No, If No you must apply ⇨	I have a pending application for AHCCCS ☐ Yes ☐ No Case # _____ Date scheduled to discuss eligibility _____/_____/_____	**I have an** AHCCCS denial letter from AHCCCS ☐ **Yes** ☐ **No** (Attach copy of letter)

Medicare - if eligible for Medicare, you must apply for Part D and Extra Help/LIS to be eligible for ADAP

I'm eligible for Medicare ☐ **Yes, date started** ___/___/___ ⇨ ☐ **No, date eligible** ___/___/_____ Have you applied? ☐ **Yes** ☐ **No**	If Yes, eligible for Medicare, Covered under Medicare Part D (Prescription plan)? ☐ **Yes** ☐ **No** If Yes, * Provide a copy of your card	If Yes, eligible for Medicare, Applied for Extra Help/LIS ☐ **Yes** ☐ **No** Eligible for Extra Help/LIS? ☐ **Yes,** attach award letter and indicate Subsidy _____% ☐ **No,** attach denial letter

Other Governmental Health Insurance Programs

I am eligible health insurance under: Indian Health Service ☐ **Yes** ☐ **No** If Yes, are you receiving health insurance or services from the Indian Health Services? ☐ Yes ☐ No	Did you ever serve on **active duty** in the Air Force, Army, Coast Guard, Marines, Navy, or as a National Guardsman? ☐ **Yes** ☐ **No** Are you eligible for health services from the VA**?** ☐ **Yes** ☐ **No** Are you receiving health services from the VA**?** ☐ **Yes** ☐ **No**

Health Insurance

I have health insurance ☐ **Yes** ☐ **No**

If Yes, Provide the a copy of your insurance card and the following:

Insurance Company Name:_____ Phone Number: _____

Policy Number:_____ Member Number: _____

Does your health insurance provide coverage for prescription drugs? ☐ **Yes** ☐ **No**

Which of your prescribed HIV medication(s) are NOT covered by the plan? Please list or attach _____

What is the maximum of your prescription drug benefit per year? $_____

What are your monthly prescription drug (out of pocket) co-payments? $_____

What are your plan's annual deductibles? $_____

Copies of your health insurance formulary and the policy description are required.

I am eligible for health insurance but am not covered. ☐ **Yes** ☐ **No**

Explain_____

If Yes, I am eligible for : ☐ **Employer-based** ☐ **COBRA** ☐ **Family/Other Person's Policy** ☐ **Other Policy**

Have you applied for coverage? ☐ **Yes** ☐ **No, If No,** When are you eligible to apply for coverage? ____/___/____

Does the health insurance provide coverage for prescription drugs? ☐ **Yes** ☐ **No**

Copies of the health insurance costs (premiums and drug co-pays), formulary and the policy description are required.

ARIZONA DEPARTMENT OF HEALTH SERVICES
AIDS DRUG ASSISTANCE PROGRAM (ADAP) APPLICATION
(Under Provision of *A.A.C. R9-6-401*, et seq)

Applicant Certification & Authorization of Release of Information

I agree that I or my designated representative must provide AZ ADAP proof of ineligibility for enrollment for AHCCCS (Arizona Health Care Cost Containment System) and/or for Medicare Part D low-income subsidy, if not provided with this application. I also agree that I or my designated representative must provide AZ ADAP proof of enrollment in a Medicare drug plan, if I am eligible for Medicare, if not provided with this application.

I grant permission to AZ ADAP to discuss this application with AHCCCS, for the purpose of determining AHCCCS eligibility, with Medicare and the Social Security Administration for the purpose of determining eligibility for a low-income subsidy and enrollment in a Medicare drug plan, with my primary care provider or their designee to confirm clinical information and acquire test results related to the service I am requesting, with the vendor pharmacy to assist with drug distribution, and with any other entity as necessary to establish eligibility for enrollment in AZ ADAP. Permission is granted for a period of one year from the date of signature.

I or my designated representative agrees to notify the AZ ADAP of any changes that affect my eligibility within 30 calendar days. Such changes include: any change in family income, household size, residential or mailing address, phone number, annual family income, and employment status, availability of insurance coverage, AHCCCS eligibility, or primary care provider.

I understand that my AZ ADAP eligibility will terminate if I do not refill my AZ ADAP covered medications for over 90 days.

I certify that to the best of my knowledge and belief, I am eligible for AZ ADAP and all statements made herein regarding personal and other non-medical information are accurate and complete. I certify that I am not eligible for any health insurance plan that would provide the support for which I am applying, other than those which I have declared.

I understand that my failure to be accurate and complete may prevent or delay a determination of eligibility to receive assistance from AZ ADAP. I understand if there is any discrepancy in the documents provided to AZ ADAP I must present government issued documentation to confirm my identity.

I understand that AZ ADAP ceases to provide drugs when available funding is exhausted or terminated. AZ ADAP is not an entitlement program and does not create a right to assistance absent available funding (R9-6-402).

Applicant Name (PRINT)	Applicant or parent/guardian Signature	Date

Return this application to
Office of HIV, STD and Hepatitis Services
ADAP
150 North 18th Avenue Suite 110
Phoenix, AZ 85007-3233
1- (800) 334-1540
Fax: (602) 364-3263

ARIZONA DEPARTMENT OF HEALTH SERVICES

Primary Care Provider Information – to be complete by Prescribing Medical Care Provider

6 Month Continuing Enrollment Form

AIDS DRUG ASSISTANCE PROGRAM (ADAP) APPLICATION

(Under Provision of *A.A.C. R9-6-401*, et seq)

APPLICANT'S NAME: _____Date of Birth: _____

PRIMARY CARE PROVIDER'S NAME: _____

MEDICAL LICENSE NUMBER: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ Fax Number: (_____) _____

TESTS	**RESULTS**	**DATE OF TEST**
CD_4 CELL COUNT (required within last 6 months)	_____	_____
VIRAL LOAD (most recent)	_____	_____

Medication(s) prescribed from the most current ADAP Formulary

[PLEASE list full prescription below or provide a copy of prescriptions-INCLUDE ALL PRESCRIPTIONS]:

Drug	Dosage	Quantity	Instructions	# Refills

I certify this applicant has been diagnosed as having HIV infection.

I understand that I shall notify the vendor pharmacy within 7 calendar days of the following:

* Prescribing a new medication
* Discontinuing a medication

I agree to notify the Arizona ADAP program within 14 calendar days following my notification of:

* Death of a patient/client,
* Change in the HIV PCP

I certify that to the best of my knowledge and belief all information, I have provided to AZ ADAP is accurate and complete.

_____ _____

Signature of Primary Care Provider Date

RETURN TO:

OFFICE OF HIV, STD, and Hepatitis Services
AIDS Drug Assistance Program (ADAP)
150 North 18th Avenue, Suite 110
Phoenix, AZ 85007-3233
Fax: (602) 364-3263

Attachment A. ADAP Eligibility Requirements Summary

Eligibility is defined is Arizona Administrative Code at http://www.azsos.gov/public_services/Title_09/9-06.htm#Article_4 as follows:

R9-6-403. Eligibility Requirements

An individual is eligible to enroll in ADAP if the individual:

1. Has a diagnosis of HIV infection from a physician, registered nurse practitioner, or physician assistant;
2. Is a resident of Arizona, as established by documentation that complies with R9-6-404(A)(9);
3. Has an annual family income that is less than or equal to 300% of the poverty level;
4. Satisfies one of the following:
    a. Has no health insurance coverage;
    b. Has health insurance coverage that:
        i. Does not cover drugs, or
        ii. Does not include on its formulary at least one of the drugs prescribed for the individual that is on the ADAP formulary;
    c. Is an American Indian or Alaska Native who:
        i. Is eligible for, but chooses not to use, the Indian Health Service to receive drugs; and
        ii. Either has no other health insurance coverage or has health insurance coverage that:
        (1) Does not cover drugs, or
        (2) Does not include on its formulary at least one of the drugs prescribed for the individual that is on the ADAP formulary; or
    d. Is a veteran who:
        i. Is eligible for, but chooses not to use, Veterans Health Administration benefits to receive drugs; and
        ii. Either has no other health insurance coverage or has health insurance coverage that:
        (1) Does not cover drugs, or
        (2) Does not include on its formulary at least one of the drugs prescribed for the individual that is on the ADAP formulary;
5. Is ineligible for enrollment in AHCCCS, as established by documentation issued by AHCCCS; **and**
6. If eligible for Medicare:
    a. Is ineligible for a full low-income subsidy, as established by documentation issued by the Social Security Administration; **and**
    b. Has enrolled in a Medicare drug plan.

Attachment B. Proof of Residency

To be eligible for ADAP, an applicant must be a resident of Arizona (AAC R9-6-403.2). Arizona Administrative Code defines Arizona residency as follows (see http://www.azsos.gov/public_services/Title_09/9-06.htm#Article_4)

R9-6-401.53. "Resident" means an individual who has a place of habitation in Arizona and lives in Arizona as other than a tourist.

Per State Rules R9-6-404.A.9, the Arizona ADAP program requires proof of Arizona residency. Proof can be demonstrated by attaching documentation from the following STEP 1, 2 or 3.

STEP 1: requires 1 item from list, circle attached	STEP 2: requires 2 items, circle the items attached	STEP 3: requires 2 items, circle the items attached
Public assistance documents w/in last 60 days; AHCCCS-current documents w/in 6 mo; Social Security Administration or Dept of Veteran's Affairs eligibility documents; DES-UI current documents; Property tax statement-most recent; Homeowner's assoc fee w/in 60 days; Current lease agreement; Mortgage statement-most recent year IF NONE GO TO STEP 2: ⇨	Utility bill; Tax bill; W-2; Pay check stub; Bank statement; Driver's license-AZ; AZ vehicle registration; AZ ID card; Tribal enrollment; US Immigration; ID card; IF LESS THAN 2 GO TO STEP 3: ⇨	Any step 2 item w/in 60 days; Non-permanent housing letter; Community service organization verifying homeless status & AZ resident; Credit card or other bill; Vehicle insurance card; Voter registration or other official doc; Case manager statement/home visit; Primary care provider statement;

Attachment C. Definitions of Family and Income

To be eligible for ADAP, an applicant must have annual family income that is less than or equal to 300% of the poverty level (AAC R9-6-403.3). Arizona Administrative Code defines Arizona family and income as follows (see http://www.azsos.gov/public_services/Title_09/9-06.htm#Article_4)

R9-6-401.23 "Family unit" means:

a. A group of individuals residing together who are related by birth, marriage, or adoption; or

b. An individual who:

i. Does not reside with another individual; or

ii Resides only with another individual or group of individuals to whom the individual is unrelated by birth, marriage, or adoption.

R9-6-401.20 Earned Income: a. Wages, b. Commissions and Fees, c. Salaries and tips, d. Self Employment, e. Profit from Rent, f. any other monetary payments for work performed or rental of property.

R9-6-401.65 Unearned Income: a. Unemployment Insurance, b. Worker's Comp, c. Disability Payments, d. SSI/SSDI, e. TANF/Public Assistance, f. Insurance or Annuity Payments, g. Retirement or Pension Payments, h. strike benefits, i. training stipends, j. Child Support, k. Alimony, l. Military family allotments, m. Regular support from those not living in household, n. investment income, o. royalty payments, p. periodic payments from trusts or estates, q. other monetary payments

REQUIRED DOCUMATION FOR INCOME:

R9-6-404.A.

7. Proof of annual family income, including the following items as applicable to the applicant's family unit:

a. For each job held by an adult in the family unit:

i. Paycheck stubs from the 30 calendar days before the date of application, or

ii. A statement from the employer listing gross wages for the 30 calendar days before the date of application;

b. From each self-employed adult in the family unit, documentation of the current net income from self-employment, such as:

i. An income tax return submitted for the previous tax year to the U.S. Internal Revenue Service or the Arizona Department of Revenue;

ii. The Internal Revenue Service Forms 1099 prepared for the previous tax year for the self-employed adult in the family unit;

iii. A profit and loss statement for the self-employed adult's business; or

iv. Bank statements from the self-employed adult's checking and savings accounts;

c. A letter from each entity providing public assistance to an adult in the family unit, describing payments from public assistance;

d. A letter from an entity providing a monetary award to an adult in the family unit to cover educational expenses other than tuition, describing the monetary award; and

e. Documentation showing the amount and source of any regular monetary payments received by an adult in the family unit from sources other than those specified in subsection (A)(7)(a) through subsection (A)(7)(d);

8. If the applicant or the applicant's representative has stated on the form specified in subsection (A)(1) that the applicant has no source of regular monetary payments and is unable to provide any of the documentation specified in subsection (A)(7), a Department-provided form, completed and signed within 30 calendar days before the date of application, containing:

a. Information completed by the applicant or the applicant's representative stating whether:

i. An adult in the applicant's family unit receives money from intermittent work performed by the adult in the family unit for which no paycheck stub is received and, if so, the average monthly earnings, and the adult's occupation;

ii. The applicant is homeless or living in a shelter;

iii. The applicant is receiving assistance from another individual; and

iv. The applicant has another source of assistance for obtaining food, water, housing, and clothing, and, if so, an identification of the source;

b. A statement by the applicant or the applicant's representative attesting that to the best of the knowledge and belief of the applicant or the applicant's representative, the information submitted under subsection (A)(8)(a) is accurate and complete;

c. The dated signature of the applicant or the applicant's representative;

d. A statement by the applicant's case manager or primary care provider attesting that to the best of the knowledge and belief of the applicant's case manager or primary care provider the information submitted under subsection (A)(8)(a) is accurate and complete; and

e. The dated signature of the applicant's case manager or primary care provider;

R9-6-404.C. For purposes of enrollment in ADAP, an applicant or the applicant's representative may report annual family income using actual family income for the most recent 12 months or estimated annual family income determined by multiplying the most recent monthly family income by 12.

Attachment D. CERTIFICATION OF INCOME & OR SUPPORT

I, _____, confirm that I am supporting myself in the following manner (initial and complete all that apply):

_____ I or an adult in my family unit receives money from intermittent work performed for which no paycheck stub is received.
The average monthly earnings are: $_____
The occupation is for which these monies are earned is: _____;

_____ I am homeless or living in a shelter;

_____ I am receiving assistance from another individual. Describe:_____.

_____ I am receiving another source of assistance for obtaining food, water, housing, and clothing.
Please specify the source of the assistance_____.

I attest that to the best of my knowledge and belief that the information submitted is accurate and complete.

_____ _____
Applicant Signature Date

I certify that to the best of my knowledge and belief that the information submitted is accurate and complete.

_____ _____
Case Manager or Primary Care Provider Signature Date